-APPLICATION FOR TELECOMMUNICATIONS EQUIPMENT-

Return to: MTAP; PO Box 4210; Helena, MT 59604

MTAP OFFICE USE:

DATE RECEIVED:_____/_____/_____ CLIENT ID #:_____
AWACS ID# : _____

APPLICATION IS: APPROVED____ DENIED____ MISSING INFORMATION____

GENERAL INFORMATION: ☐ ***MALE*** ☐ ***FEMALE***

REQUIRED INFORMATION MARKED WITH **

***SSN_____ **Birthdate:_____/_____/_____*

***Name:_____*
Last First MI

***Street Address:_____*
Street City Zip

***Mailing Address:_____*
RR, HC, PO Box City Zip

***Land Line Phone #_____ **Phone Service Provider: _____*

E-Mail Address: _____

*** I am a Montana Resident ___Yes ___No*

Additional Contact information: Please do not list yourself

Name: _____ Phone #:_____

Address:_____ City:_____ Zip:_____

Contact's Relationship to Applicant:_____

How did you hear about MTAP?

___ Newspaper
___ TV
___ Internet
___ Presentation
___ Audiologist
___ SLP
___ Phone Company
___ Phone Book
___ Friend
___ Family
___ Mailing Piece
___ Other, Please Specify:_____

Would you like to receive the MTAP newsletter? ___Yes ___No

*****DISABILITY AND EQUIPMENT INFORMATION***
The applicant is (check all that apply):
NOTE: *Vision disability **MUST** be paired with one of the other listed disabilities to receive MTAP Services*

___Deaf
___Deaf/Blind
___Deaf with Cochlear Implant
___Hard of Hearing
___Visually Disabled
___Speech Disabled
___Mobility Disabled

If Mobility Disabled, please describe:_____
If Hard of Hearing or Deaf, do you wear hearing aid(s)? _____, one or two hearing aids _____
List any other pertinent information regarding your disability: _____

The applicant requests (check any that may apply):

___ *Amplified Telephone*
___ *TTY*
___ *"CapTel" Captioned Telephone*
___ *Weak Speech Amplification*
___ *Artificial Larynx*
___ *" Hands Free" Speaker Phone*
___ *Loud Ringer*
___ *Light Signaler (ring flasher)*
___ *I need MTAP to help me determine what equipment will work the best for me.*

****INCOME INFORMATION*** ***Please provide a DOLLAR AMOUNT for income***

** *Total Number of Persons in Household: _____*

** *Total Annual Household Gross Income $_____per year*

Note: Participation in our program is based on household income along with the number of persons which that income supports (family size) . Applicant's family income must be lower than 250% of the current year's Federal Poverty Guidelines (see "Instructions and Information" for amounts) to qualify.

VERIFIER INFORMATION

*The **professional** listed below can verify my disability:*
*Note: Please **DO NOT list yourself, a relative, your pastor or your landlord**. A verifier can be any medical or hearing professional, a care-giver or social worker who can verify your hearing, speech or mobility disability*

You do NOT need a signature from the verifier.

** *Name:_____ Telephone #:_____*

Address:_____City:_____Zipcode:_____

Verifier's Occupation (check one):

___*Licensed Physician*
___*Voc. Rehab. Counselor*
___*Audiologist*
___*Speech Pathologist*
___*Hearing Aid Specialist*
___*Hearing Aid Dispenser*
___*Other Please Specify Other: _____*

APPLICATION CERTIFICATION

I certify under penalty of the offense of false swearing (Section 45-7-202, MCA), that I meet the definition of Deaf, Deaf/Blind, Hard of Hearing, Speech Disabled, or Motion/Mobility Disabled given on the application instruction sheet and that all statements made by me are true and correct to the best of my knowledge. I also agree to inform the Montana Telecommunications Access Program (MTAP) of any changes to this information as long as I am receiving services.

** *Applicant's Signature:_____* ***Date:____/____/_____*

Responsible Party Signature (if applicant is unable to sign):

Signature: _____ Date: :____/____/_____

Parent/Guardian Signature: _____ Date:____/____/_____
(Required if applicant is under the age of 18)